STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Precise Care, LLC
2449 North Avenue
Bridgeport, CT 06604

CONSENT ORDER

WHEREAS, Precise Care, LLC (hereinafter the "Licensee"), has been issued License No. 0018 to operate a Home Health Care Agency, (hereinafter the "Facility") under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates commencing on December 23, 2008 and concluding on January 9, 2009 with additional information received through February 23, 2009; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated February 25, 2009 (Exhibit A – copy attached); and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Sandra Joseph, its President, hereby stipulate and agree as follows:

1. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Supervisor of Clinical Services, shall ensure substantial compliance with the following:
    a. Sufficient and qualified staff shall be employed at all times, at all offices of the agency. Said individuals shall be qualified in accordance with federal and state

laws and regulations which are applicable to the care and services provided by a home health care agency. The full-time Administrator and/or Supervisor of Clinical services shall, at all times, function in the capacity as described in the respective job descriptions;

b. Care for all patients shall follow a written plan of care established by the physician; the plan of treatment shall be signed by the physician within twenty-one (21) days of the onset of services. The plan of treatment shall be reviewed at least every sixty (60) days;

c. Patient treatments, therapies and medications are administered and documented as prescribed by the physician and in accordance with each patient's comprehensive care plan;

d. Medication responses are assessed, profiles are complete or discrepancies are clarified with the physician in a timely manner;

e. Patient assessments and re-assessments are performed in a timely, accurate and comprehensive manner and reflect the condition of the patient;

f. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;

g. Summary reports for all patients shall be forwarded to the physician within ten (10) days of admission to the agency and every sixty (60) days thereafter;

h. The personal physician or covering physician shall be notified in a timely manner of any significant changes in the patient's condition including, but not limited to deterioration of mental and/or physical status;

i. All care provided by licensed practical nurses shall be under the direction and supervision of a registered nurse;

j. Homemaker-home health aides shall be supervised as often as necessary based on the patient's condition;

k. Patients shall be discharged appropriately in accordance with agency policy and in a timely manner; and

l. All direct care staff shall be oriented, at the time of hire, to agency policies and their role as identified in the job description(s).

2. The Licensee shall within fourteen (14) days of the effective date of this Consent Order and/or in accordance with the facility's plan of correction, review or develop and/or revise all policies and procedures as necessary, which are pertinent to patient assessment; development, implementation and revision of the plan of care; medication administration; notification of the physician of a change in the condition and/or status of the patient and discharge of the patient.
3. The Licensee shall within twenty-one (21) days of the effective date of this Consent Order, review and revise as necessary, each patient's plan of care based upon the patient's current assessment.
4. The Licensee shall within thirty (30) days of the effective date of this Consent Order and/or in accordance with the facility's plan of correction, in-service all direct service staff on topics relevant to the provisions of Sections 1, 2 and 3 of this document. The Licensee shall maintain an attendance roster of all in-service presentations that shall be available to the Department for a period of two (2) years.
5. The Supervisor of Clinical Services shall be responsible for ensuring that all care provided to patients by all caregivers is in accordance with individual comprehensive care plans and shall be provided with the following:
   a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;
   b. A training program which clearly delineates the Supervisor of Clinical Service's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation.
6. The Licensee shall, within thirty (30) days of the effective date of this Consent Order build into the Licensee's current quality assurance program a mechanism to evaluate the clinical competency of all professional direct service staff. Any registered nurse, not previously employed by a home health care agency as a primary care nurse, shall undergo an additional orientation program to include but not be limited to the role of the primary care nurse and case management of the patient. The caseload of said individual(s) shall be reviewed and supervised by the Supervisor of Clinical Services at least weekly for the first three months of employment and then monthly for the next three months. The agency shall develop a mechanism for remediation should the six (6) month evaluation of clinical competence be unsatisfactory. At a minimum, the Supervisor of Clinical Services shall quarterly conduct joint home visits with each

primary care nurse ("PCN"), as well as a clinical record audit of twenty (20) percent of the PCN's current caseload, to assess clinical competence and to initiate a program of remediation, as applicable. The administrator shall prepare a report of the program's progress toward goals to be presented to the Professional Advisory Committee at its meetings. Said reports shall be available for review by the Department for a period of two (2) years.

7. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe. The assigned individual shall submit monthly reports to the Department regarding the provisions contained within this document.
8. The Licensee's Administrator, and the Supervisor of Clinical Services shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at eight (8) week intervals for the following six (6) months. The meetings shall include discussions of issues related to the care and services provided by the Licensee.
9. The Licensee shall ensure that the established quarterly Clinical Record Review program to review adherence to agency policies in the provision of care and services to patients is conducted and includes those issues identified in the February 18, 2009 violation letter. All findings and recommendations shall be acted upon and reported to the Professional Advisory Committee and the governing authority. Minutes of the QAP/Clinical Record Review meetings and reports to the Professional Advisory Committee and governing authority shall be kept for a minimum of three (3) years and made available for review upon request of the Department.
10. Upon execution of and for the duration of this Consent Order, Precise Care, LLC shall petition the Department for approval to open any additional patient service office(s) and/or to grant any new Home Health Care Agency license in the State of Connecticut.
11. In accordance with Connecticut General Statutes Section 19a-494(a)(5), the license of Precise Care, LLC is placed on probation for a period of the term of this Consent Order.
12. The Licensee shall pay a monetary penalty to the Department in the amount of five thousand dollars ($5,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective

date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Victoria V. Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

13. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
14. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
15. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
16. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
17. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

*

*

WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

PRECISE CARE, LLC
OF BRIDGEPORT, CT - LICENSEE

4/2/09
Date

By: Sandra Joseph
Sandra Joseph, President

STATE OF Connecticut)

County of Fairfield) ss Bridgeport 2009

Personally appeared the above named Sandra Joseph and made oath to the truth of the statements contained herein.

My Commission Expires
May 31, 2013

My Commission Expires: _____
(If Notary Public)

Notary Public [✓]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

April 6, 2009
Date

By: Joan D Leavitt
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

RECEIVED
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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
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February 25, 2009

Sandra Joseph, RN, Administrator/SCS
Precise Care , LLC
2449 North Avenue
Bridgeport, CT 06604

Dear :

Unannounced visits were made to Precise Care , LLC on December 23, 24, 26, 29, 30, 31, 2008 and January 5, 6, 9, 2009 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations and a licensing inspections with additional information received through February 23, 2009.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for March 11, 2009 at 10:00 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Victoria V. Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SNC:NC:

c. Nurse Consultant
Complaint #CT8802
Complaint #CT8255
Complaint #CT 9178

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

EXHIBIT A

DATE(S) OF VISIT: December 23, 24, 26, 29, 30, 31, 2008 and January 5, 6, 9, 2009 with additional information received through February 23, 2009

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(b) General requirements.

1. The governing body failed to assume responsibility for services provided by the agency and to ensure the safety and quality of care rendered to Patient #s 1-15 and their families based on the deficiencies identified in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(c) General requirements.

2. Based on review of the Professional Advisory Committee (PAC) minutes for the years 2007 and 2008 it was determined that the PAC failed to meet at least 2 times per year and/or failed to complete written minutes of the activities of the PAC, and/or failed to participate in the quality assurance program. The findings include:

a. Only one PAC meeting was held in 2007 on July 21 and only one meeting was held in 2008 on January 5.
b. The minutes of the PAC meetings failed to reflect the required agenda and agency policy review.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(d) General requirements.

3. Based on agency documentation and staff interviews it was determined that the administrator failed to organize and direct the agency's ongoing functions and to ensure the safety and quality of care rendered to Patient #s 1-15 based on the deficiencies identified in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68D68(e) General requirements.

4. The supervisor of clinical services failed to ensure the safety and quality of care rendered to Patient #s 1-15 and their families based on the deficiencies identified in this document. The findings include:

a. Patient #13 had a start of care date of 9/9/08. Diagnosis was diastolic heart failure. The W-10 from Hospital #4 identified that the patient was admitted on 9/2/08 and discharged on 9/5/08 with CHF exacerbation and a history of congestive heart failure (CHF) with diastolic dysfunction, hypertension, diabetes mellitus, and a left lower lobe nodule. The certification and plan of care dated 9/9/08 to

EXHIBIT A

DATE(S) OF VISIT: December 23, 24, 26, 29, 30, 31, 2008 and January 5, 6, 9, 2009 with additional information received through February 23, 2009

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

11/7/08 directed that skilled nursing visits be made 5-7 times per week and home health aide to visit 3-5 times per week.
On 9/10/08 clinical record documentation identified that the home health aide was oriented and the plan of care was reviewed with the physician by RN #2; however during an interview with RN #2 on 1/14/09 she stated that she did not make any visits to and/or was not involved with the care of Patient #13.
During an interview with the Administrator/SCS on 1/14/09, she was unable to identify any information regarding this patient and was unaware of this entry; at that time she was concentrating on learning the computer system and other RNs were supervising the staff nurses.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(e) General requirements.

5. Based on review of the organizational administrative positions and staff interview, it was determined that the agency failed to employ a full time supervisor of clinical services (SCS) from October 2008 to present. The findings include:

a. On interview 12/23/08 the agency administrator who also functioned in the role of SCS, stated that the agency failed to hire a separate SCS when the agency employed 6 or more full time professional staff. The Administrator/SCS indicated that the agency had greater than 6 full time professional staff from October 2008 through the present.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(2)(3)(A)(C)(D)(4) Services and/or 19-13-D74(a)(1)(2)(b) Administration of medicines and/or 19-13-D72(a)(2)(D) Patient care policies.

6. Based on clinical record review, staff interviews and home visit observations, it was determined that for four (4) of fifteen (15) patients (Patient #s 1, 7, 12, 14) the nurse failed to assess the patient when the patient experienced a change in condition and/or nursing needs. The findings include:

a. Patient #1 had a documented start of care date of "11/27/08". Diagnosis included malignancy of the pancreatic duct. The certification and plan of care dated "11/30/08 through 1/28/09" identified that the patient required skilled nursing visits 1-3 times a week; orders included to instruct and administer TPN, teach daily hygiene, infection control, and medication management as well as assess pain. The plan of care listed no medication for pain management. A skilled visit note written on 11/27/08 identified that the patient's vital signs were stable, complained of generalized pain, "ordered for pain medication". The start of care OASIS/comprehensive assessment dated 11/30/08 identified that the patient was alert and oriented, consistently anxious, had feelings of depression and hopelessness, was totally dependent for all activities of daily living, had consistent intractable pain. A hospital W-10 dated 12/17/08 identified

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

that the patient was admitted on 12/2/08 and discharged on 12/17/08 with additional diagnoses of pleural effusion, dehydration and gastric outlet syndrome. New medication orders included a Fentanyl patch, and Oxycodone with APAP as needed for pain. The Resumption of Care (ROC) OASIS assessment dated 12/18/08, identified that the spouse who is the primary care giver (PCG), was extremely anxious and required more assistance, and that skilled nursing visits would continue 5-7 times per week. A new certification and plan of care was developed and dated 11/27/08-1/25/09 that identified the new medications, to change the PICC line dressing weekly and to notify the physician of a 3 pound weight gain.
From 12/18/08 to 12/21/08 nursing notes identified that the PCG was becoming more comfortable with TPN administration and nursing visits would be decreased.
The nursing note dated 12/22/08 identified that the PCG had a very high anxiety level. Documentation was lacking of any additional assessment of the PCG's increased anxiety and/or collaboration regarding interventions to address the changed needs. The 12/22/08 note also identified that this was the last visit and that RN #1 had been told by the Administrator/SCS that the patient had been admitted to the hospital. A communication note dated 12/23/08 identified a case conference with the physician and that the patient had been admitted to the hospital with an elevated temp.
The hospital W-10 dated 1/6/09 identified that the patient was admitted on 12/30/08 and discharged on 1/6/09 with a new diagnosis of necrotic liver metastasis.
Interviews with RN #1 on 1/21/09 identified that when she started the case on 11/26/08, she was told to just instruct on the TPN.

b. Client #7 had a start of care date of 10/23/08 with the diagnoses of diabetes mellitus (DM) type I and left foot ulcer. The certification period of 10/23/08 to 12/21/08 ordered skilled nursing visits 1-3 times per week to teach patient/care giver proper IV solutions/medications using aseptic technique, trouble shooting, infusions and equipment, assess signs and symptoms of diabetes, report changes to physician, teach diet, teach infection control, teach risk/dose/route/frequency of medications; teach wound care, wound assessment and provide physician ordered wound care.
The clinical record identified that skilled nursing visits were made on 10/24/08 and 11/20/08 with a discharge summary of 11/21/08.
The clinical record lacked documentation that the RN/LPN assessed Patient #1's diabetic status, taught diet, instructed on medications and/or taught and/or documented the wound care status as the physician ordered.
Interview with the Administrator/SCS on 12/30/08 identified that she was not aware of the particulars of Patient #7's care other than that the physician was doing the dressing changes.

c. Patient #12 had a start of care date of 3/15/08. The diagnosis was bacteremia. The initial plan of care dated 3/15/08 to 5/13/08 included skilled nursing 1-2x a week to assess grooming ability, change the peripherally inserted central catheter (PICC) line dressing weekly, teach diet and activity guidelines, teach use/risk/dose/route/frequency of medications; teach use of medication dispensing device, assessment of medication management; teach stress control and coping skills. The patient was referred from the hospital following admission for a urinary tract infection. The hospital Interagency Referral

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Form (W-10) dated 3/14/08 included diagnoses of depression, mesothelioma with omental metastases, palliative care, UTI, seizure disorder, meningioma with history of hydrocephalus, status post VP shunt, GERD and Parkinson's disease and noted to maintain the PICC line/catheter care per protocol and flush once a week.

The nursing notes from 3/15/08 to 8/31/08 identified that the nurse changed the PICC line dressing, flushed the lines and that the patient was not experiencing pain. Documentation was lacking that the nurse assessed temperature and vital signs (VS) every visit, discussed/assessed/ instructed on diet, instructed the patient/caregiver on the medication regime and management per the plan of care. The nurse failed to assess/document if the patient experienced any progression of disease (hospitalized 6/08 with a progressive cancer diagnosis) and/or failed to assess the patient's nutrition/hydration/ functional status.

The nursing (LPN) notes dated 9/6/08 and 9/13/08 identified that the patient was getting weaker and having medication for pain. The notes lacked assessment of the patient's health status including a pain assessment, medications/schedule, the increased weakness and/or any communication with the RN and/or the physician. The clinical record lacked documentation that the patient was visited after 9/13/08 but was discharged on 10/9/08 to hospice care.

d. Patient #14 had a start of care date of 1/3/09. Diagnoses included acute renal failure and dehydration. The patient was hospitalized from 11/21/08 to 1/2/09. The W-10 from the hospital dated 1/2/09 noted that the patient was alert, oriented, anxious, confused at times, lived alone and had impaired mobility, at risk for falls, a history of Oxycontin use and a Hickman port in place for TPN administration. The W-10 also identified a stage 1 and stage 2 pressure sore on coccyx covered with Tegaderm/Xeroform, and that the patient had a "grossly inadequate diet", needed prompts to eat, and weighed 130 lbs. The W-10 instructions included: assess for an aide, evaluate home safety, refer for PT, evaluate medication compliance, effect, knowledge, monitor nutrition and peripheral edema, weigh daily, educate the patient/caregiver regarding the heparin flush and dressing change, and assess for infection/dislodgement of the catheter.

The plan of care dated 1/3/09 included skilled nursing 1-3x a week to teach injections, visit weekly for dressing changes to PICC line, instruct the patient on flushing technique with heparin, assess coccyx area and apply Tegaderm and Xeroform, assess pain, renal status, encourage oral intake, and teach TPN cycle. Home health aide (H-HHA) was to visit 1-3x a week to assist with ADLs and IADLs. The nurse was to refer for a PT evaluation.

The admission OASIS/comprehensive assessment of 1/3/09 completed by RN #1 identified that the Patient #14 could independently administer all medications including parental medications and was independent in all ADLs and most IADLs. Documentation was lacking that the patient demonstrated compliance and proficiency with the medication regime. RN #1 changed the PICC line dressing, and observed that the patient had red, edematous arms with 2+ pitting edema and was emaciated. The assessment dated 1/3/09 failed to include vital signs (VS), temperature and a weight.

The next visit was made on 1/6/09 when the patient's daughter told RN #1 that the patient was "misusing medications because the previous evening the patient had instructed the daughter to leave all the bottles opened at the bedside and he/she was acting loopy". EMS was called to the home however

the patient refused to go to the hospital. RN #1 and the daughter determined the patient's current medications based on the dates on the bottles and did not verify the current medications using an accurate medication list.
A home visit at 4:00 PM on 1/6/09 identified that the patient was very upset regarding the morning visit by RN #1, stated that she walked in the door with an attitude, did not talk to him/her to allow him/her to explain that he/she had a lot of pain the previous evening from out trips with daughter and by choice took 2 doses of pain medication which made him/her groggy. The patient stated that on the visit of 1/3/09, RN #1 did not talk about and/or instruct him/her regarding medications, did not assess his/her ability to administer Lovenox or TPN, did not review the TPN schedule, and/or assess pain, swelling of both arms and ankles, take temperatures or weights; medications were assessed during the visit of 1/6/09 by looking at the medication bottles.
During the surveyor visit the patient ate a sandwich however on interview with RN #1 on 1/7/09, she stated she was unsure if he/she was able to have oral foods.
Interview with the Administrator/SCS on 1/5/09 identified that she E-faxed the W-10 to RN #1 before the admission visit.
Interview with RN #1 on 1/7/09 identified that she was unaware of an E-fax and at the time of both visits to the patient (1/3/09, 1/6/09), she did not have either the W-10 and/or the plan of care with her. She stated that she had been told to only do a teaching visit on 1/3/09, filled out a one page skilled visit sheet which did not include a complete assessment, however the start of care assessment was dated as completed on 1/3/09 by RN #1.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-G 170 D69(a)(3)(C)(D) services and/or D73(b) Patient care plan.

7. Based on review of clinical records and staff interviews, it was determined that for five (5) of fifteen (15) patients (Patient #s 1, 8, 12, 13, 15) the RN failed to furnish services in accordance with the plan of care. The findings include:

a. Patient #1 with a start of care date of 11/27/08 had diagnoses that included a malignancy of the pancreatic duct with chemotherapy. The certification and plan of care dated 11/30/08 through 1/28/09, documented as written by RN #1, identified that the patient required skilled nursing visits 1-3 times a week to instruct and administer TPN, assess homebound status, teach daily hygiene, infection control, and medication management. Nursing visits were documented between 11/27/08 and 12/22/08. On interview 1/5/09 the PCG identified that the patient was admitted to the hospital on 12/30/08 with an elevated temp and that the patient had no nursing visits for the week prior to hospitalization. The Administrator/SCS and RN #1 identified during an interview on 1/5/09 that they could not explain why no visits were made between 12/22 and12/30/08 despite the PCG's call on 12/24/08 requesting a home health aide.

b. Patient #8 had a start of care assessment date of 4/12/08. A skilled nursing infusion visit was

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

conducted on 4/26/08 to administer intravenous immune globulin (IVIG) by RN #4 (PCN). Physician orders identified to infuse every 3 weeks. Diagnosis was common variable immune deficiency. Orders from Hospital #2 were dated 3/20/08 that identified to admit the patient to homecare, vital signs per protocol, insert IV, Tylenol and Benadryl PRN. Additional orders dated 4/3/08 identify that IVIG/GGSD powder should be increased to 2.5 GM every 3 weeks. A skilled nursing initial evaluation assessment was not in the record at the time of the survey, however it was made available on 1/7/09 via fax by RN #4. The admission assessment identified that the patient was alert and oriented, living with supportive family, with normal status of systems, required IVIG, IV medication to run in over 5 hours via gravity. There were no formal orders sent to the MD identifying the visit and treatment plan based on the admission assessment.

c. Patient #12 had a start of care date 3/15/08. The diagnosis was bacteremia. The plan of care for the period of 3/15/08 to 5/13/08 included skilled nursing 1-2 times per week.
The clinical record lacked documentation that the patient was visited the weeks of 4/13/08, 6/8/08, 6/15/08, 8/10/08, 9/21/08 and 9/28/08.
The Administrator/SCS stated on 1/14/09 that she did not have any documentation for those visits, did not know why visits were not made for the referenced weeks, and that RN #2, the primary care nurse (PCN) and an LPN, no longer with the agency, made the visits. RN #2 stated on 1/14/09 that she was not the PCN and did not visit the patient from June to September since another nurse was the PCN.

d. Patient #13 had a start of care date of 9/9/08. Diagnosis was diastolic heart failure. The W-10 from Hospital #4 identified that the patient was admitted on 9/2/08 and discharged on 9/5/08 with CHF exacerbation and a history of congestive heart failure (CHF) with diastolic dysfunction, hypertension, diabetes mellitus, and a left lower lobe nodule; orders included 2 GM NA diet, weigh daily and report a 2 or more lb. increase to physician, follow up with potassium and magnesium check in one week and a urinalysis for hemoglobin in 1 month.
The start of care assessment dated 9/9/08 identified that the patient lived alone, was independent in all ADLs but required support for all IADLs, required assistance for medications and became short of breath (SOB) with minimal exertion requiring to rest frequently before finishing a task and could benefit from oxygen and assistance in the home. The certification and plan of care dated 9/9/08 to 11/7/08 directed that skilled nursing visits be made 5-7 times per week to assess cardio-respiratory status, arrange community resource for pain management, teach guidelines for physician notification, infection control and hygiene etc.; home health aide to visit 3-5 times per week.
A nursing note dated 9/9/08 identified that the that the patient was short of breath, had scattered wheezes, appeared to need oxygen and that meds were pre-poured for one week. The only other nursing note dated 10/15/08, completed by a LPN, identified that the patient was alert and oriented and not SOB. Documentation was lacking of any nursing visits between 9/9/08 and 10/15/08.
During an interview with the Administrator/SCS on 1/14/09, she was unable to identify any information regarding this patient as to why the visit plan was not followed and she stated that at that time she was concentrating on learning the computer system and other RNs were supervising the staff nurses.

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e. Patient #15 had a start of care date of 11/21/08. Diagnoses included Alzheimer's disease and hypertension. The plan of care dated 11/21/08 to 1/19/09 identified skilled nursing visits 1-2 times a week for 9 weeks to monitor vital signs and safety, assessment of medication management, teach medications, physician notification and emergency action. Skilled nursing visit notes identified that RN #1 made a visit on 11/21/08, and then not until 12/4/08 (2 weeks later).

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(C)(D) Services.

8. Based on clinical record review and staff interview it was determined that for one (1) of fifteen (15) patients (Patient #15) the nurse failed to provide appropriate nursing services related to the discharge of the patient. The findings include:

a. Patient #15 had a start of care date of 11/21/08. Diagnoses included Alzheimer's disease and hypertension. The plan of care dated 11/21/08 to 1/19/09 identified skilled nursing visits 1-2 times a week for 9 weeks to monitor vital signs and safety, assessment of medication management, teach medications, physician notification and emergency action as well as a home health aide 1-3 times a week for 9 weeks to assist with meals, transportation, laundry, housekeeping and shopping.
The nursing note dated 1/3/09 identified that the patient was alert and oriented and vital signs stable; there was no mention of a discharge conference and/or assessment.
During an interview on 1/9/09, the Administrator/SCS stated that the agency had received a call from the payor on 1/2/09 notifying the agency that payment for services ended as of 12/19/08 and that she (SCS) notified the PCN (RN #1) on 1/2/09 to make a discharge visit which she believed occurred on 1/3/09. On interview 1/12/09 the receptionist stated that she attempted to contact the aides on the case, was able to contact and cancel the aide who worked from 6:30 AM to 10:00 AM, but never spoke to, however left a message for H-HHA Aide #8.
On interview on 1/12/09 H-HHA Aide #8 stated she had not received the message and arrived at the patient's home on 1/5/09 at 10:00 AM, found the patient half off the bed, assisted patient back to bed and called the office telling the receptionist how she found the patient and that the patient was alone in the house. The receptionist told her to leave because the patient was discharged. The aide stated she attempted to contact the spouse but didn't reach him/her. The aide described the patient as having a good memory at times, had a shuffling, unsteady gait and liked to turn on the gas stove and cook. A report from the payor documented that the spouse, who was at work, kept attempting to call the home thinking the aides were there. At noon, with repeated phone calls and no answers, he/she contacted his/her child who left work to check on the patient. The child found the patient alone in the home, the door was locked, and the patient was on the floor sitting in urine and feces.
Interview with RN #1 on 1/21/09 identified that she was not trained by the agency regarding the role of the PCN, did not know which services this patient was receiving, and/or was not notified that the patient was to be discharged until after her visit on 1/3/09, therefore she did not notify the family and/or assess the safety of the patient and/or develop a plan with the family and/or notify the physician of the

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discharge.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(D) Services.

9. Based on clinical record review and staff interviews it was determined that for two (2) of fifteen (15) patients (Patient #s 9,12) the nurse failed to complete a comprehensive assessment in a timely manner after the start of care. The findings include:

a. Patient #9 had a start of care date of 9/13/08. Diagnoses include respiratory abnormality: pulmonary dysphasia, tracheostomy, cleft palate, limb anomalies, aortic stenosis and absence of the left kidney. The plan of care (PoC) of 9/13/08 to 11/11/08, not signed by the physician, included skilled nursing 16-24 hours daily to change G-tube site, suction patient every hour and prn, assess anxiety, phone the physician if the patient had a weight gain of 3 lbs, assess lab values, diet status and activity level, teach daily hygiene, infection control; use, dose, route/frequency of medications; medication management, teach wound care, wound assessment, signs/symptoms of GU process, teach stress control/coping skills and assess equipment management and pain. The PoC of 9/13/08 was not reflective of the total needs of a patient with multiple anomalies and complex medical needs/interventions. Interview with RN #3 (PCN) on 1/5/09 identified that she had never performed a comprehensive pediatric assessment for Patient #9. She stated that she just visited to see how the patient was doing since she did not have a specific plan of care, and was not given an agency pediatric assessment to complete when the patient was admitted. Although the PoC noted that the nurse would assess medication management the PoC identified the patient was taking no medications.

b. Patient #12 had a start of care date of 3/15/08. The diagnosis was bacteremia. The initial plan of care dated 3/15/08 to 5/13/08 included skilled nursing 1-2x a week to assess grooming ability, change the peripherally inserted central catheter (PICC) line dressing weekly, teach diet and activity guidelines, teach use/risk/dose/route/frequency of medications; teach use of medication dispensing device, assessment of medication management; teach stress control and coping skills. The start of care assessment note of 3/15/08 was documented as completed by RN #2 although the nurse's note of 3/15/08 documented completion by an LPN. RN #2 stated on 1/14/09 that she did not admit the patient and/or visit the patient on 3/15/08.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-G176 D69(a)(3)(D) Services.

10. Based on clinical record review and staff interview it was determined that for three (3) of fifteen (15) patients (Patient #s 1, 13, 15) the nurse failed to inform the physician of changes in the patient's condition and/or needs. The findings include:

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a. Patient #1 with a start of care date of 11/27/08 had diagnoses that included a malignancy of the pancreatic duct with chemotherapy. The goals for the patient were to manage medication, and/or nutrition equipment, pain control, and cancer signs and symptoms and anxiety are controlled. A skilled visit note written on 11/27/08 identified that the patient complained of generalized pain, "ordered for pain medication". The start of care OASIS/assessment dated 11/30/08 completed by RN #1 identified that the patient was alert and oriented, consistently anxious, had feelings of depression and hopelessness, was totally dependent for all activities of daily living, and had consistent intractable pain. The summary note was the same as the one written on 11/27/08 regarding the patient's pain however there were no verbal orders for any pain medication adjustments and/or nursing notes identifying communication with the physician. In an interview on 1/21/09, RN #1 stated that she had never contacted the physician.

b. Patient #13 had a start of care date of 9/9/08. Diagnosis was diastolic heart failure. The W-10 from Hospital #4 identified that the patient was admitted on 9/2/08 and discharged on 9/5/08 with CHF exacerbation and a history of congestive heart failure (CHF) with diastolic dysfunction, hypertension, diabetes mellitus, and a left lower lobe nodule; orders included 2 GM NA diet, weigh daily and report a 2 or more lb. increase to physician. The start of care assessment dated 9/9/08 identified that the patient lived alone, was independent in all ADLs but required support for all IADLs, required assistance for medications and became short of breath (SOB) with minimal exertion requiring to rest frequently before finishing a task and could benefit from oxygen and assistance in the home. The certification and plan of care dated 9/9/08 to 11/7/08 directed that skilled nursing visits be made 5-7 times per week to assess cardio-respiratory status, arrange community resource for pain management, teach guidelines for physician notification, infection control and hygiene etc.; home health aide to visit 3-5 times per week. The nursing notes dated 9/9/08 identified that the that the patient was short of breath, had scattered wheezes, appeared to need oxygen and that meds were pre-poured for one week. Documentation was lacking of notification of the physician to these changes.

c. Patient #15 had a start of care date of 11/21/08. Diagnoses included Alzheimer's disease and hypertension. The plan of care dated 11/21/08 to 1/19/09 identified skilled nursing visits 1-2 times a week for 9 weeks to monitor vital signs and safety, assessment of medication management, teach medications, physician notification and emergency action. Nursing notes from 12/14/08-12/23/08 documented by RN #1 identified respiratory changes including decreased lung sounds, shortness of breath (SOB) and wheezing, however documentation was lacking that the physician was notified of these changes.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(J) and/or (d)(4)(B) Services.

11. Based on clinical record review and staff interviews it was determined that for three (3) of three (3)

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patients (Patient #s 3, 6, 15) receiving skilled and home health aide services, the nurse failed to supervise and/or to document supervision of the home health aide every two-weeks. The findings include:

a. The clinical records for Patient #s 3, 6 and 15 who received skilled services along with home health aide services lacked documented evidence of supervision of the home health aide at least every two weeks.

b. Interview with the Administrator/SCS on 12/29/08 indicated that supervision of the aide should be documented either on the nursing visit notes and/or in the computer software.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(4) Services.

12. Based on clinical record reviews, agency policy and staff interviews, it was determined that for two (2) of fourteen (14) patients (Patient #s 9, 12) documentation was lacking that care provided by the LPN was under the direction and/or supervision of a RN. The findings include:

a. Patient #9 had a start of care date of 9/13/08 and was receiving skilled nursing 16-24 hrs/day. The clinical record from 9/13/08 to 12/20/08 indicated that all the shift nursing hours/visits were completed by an LPN. The clinical record from 9/13/08 to 12/20/08 lacked documentation that the RN directed/coordinated care with the LPNs.
RN #3 stated on 1/5/08 that she did not document the supervisions of the LPNs. She just went out to visit the patient to see how he/she was doing.

b. Patient #12 had a start of care date of 3/15/08. The patient's plans of care from 3/15/08 to 9/11/08 included skilled nursing 1-2x a week. From 3/15/08 to 9/11/08, the clinical record indicated that the weekly nursing visits were completed by the LPN. The clinical record lacked documentation to support that the RN ever conferred with and/or supervised the LPN.
RN #2 stated on 1/14/09 that she was the case manager for the patient until June 2008 and then saw the patient once in September before the patient was discharged. She stated that although she did not document communication with the LPN, the LPN would often call her.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71 (a)(1) Personnel policies.

13. Based on review of aide personnel files and staff interview, it was determined that for eight (8) employees (H-HHA #s 1, 2, 4, 5, 6, 7 and RN #s 1, 3) the agency failed to provide and/or to document provision of an agency orientation for all employees at the time of hire. The findings include:

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a. The personnel files for H-HHA #s 1, 2, 4, 5, 6, 7 with hire dates between 6/20/07 through 11/28/08, lacked documentation of an agency orientation. During interview on 12/26/08, the Administrator/SCS indicated that the agency failed to document the orientations of the home health aides.

b. Review of the active patient list on 12/30/08 identified that RN #3 was the primary care nurse for five (5) patients. During interviews with RN #3 on 12/24 and 12/26/08 during a skilled nursing visit for Patient #5, she identified that her primary responsibility was to assure that the IVs infused correctly, to change the central line dressing and the dressing on the right knee wound. She stated she was not taught to assess all the patient's needs and/or how to develop the plan of care and/or make a referral for social services and/or podiatry and/or other professional services such as therapy; how to individualize the aide's care plan regarding the dry skin, not to clip toe nails and/or to orient/instruct the aides to the patient's specific needs. She stated that these areas were the responsibility of the SCS who she contacted regularly. She further stated that she had not developed the plan of care that was sent to the physician. Documentation was lacking in the personnel folder of an orientation to the agency.

c. Review of the active patient list on 12/30/08 identified that RN #1 was the primary care nurse for 12 patients. Interview with RN #1 on 1/21/09 identified that when she became the PCN for Patient #1 on 11/26/08, for Patient #14 on 11/21/08 and for Patient #15 on 11/21/08, she was given "tasks" to be provided to the patients by the receptionist on the phone such as: instruct on TPN, and/or instruct on subcutaneous injections, and/or monitor physical status. She stated her orientation consisted of shadowing a nurse for 3 hours, she received no orientation to State or Federal regulations; was not given any written physician orders by the agency; did not know anything about insurance or even consider it when planning visits, treatments or services; never spoke to any of the patient's physicians regarding significant changes, new orders, questions etc because she thought the office staff did that. When she asked the Administrator/SCS how to develop a visit schedule she was told that if she primarily used the visit plan of 1-3 skilled visits per week it would cover the majority of cases; and/or was given no training on orienting and/or supervising the H-HHAs.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71 (a)(2) Personnel policies.

14. Based on review of the home heath aides personnel files, agency policy and staff interview, it was determined that seven (7) of seven (7) home health aides (H-HHA #s 1-7) failed to complete 12-hours of in-service education in 2008. The findings include:

a. The personnel records for H-HHA #s 1-7 failed to document in-service education for 2008.
b. Interview with the Administrator/SCS on 12/24/08 indicated that staff development in-services were not completed. The Administrator/SCS indicated that the policy for the home health aides was to complete 12-hours of in-services per year.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D71 (a)(5) Personnel policies.

15. Based on review of the personnel files and staff interview it was determined that for two (2) of seven (7) H-HHAs and for five (5) of ten (10) professional staff [H-HHA #s 3, 5; RN #s 1, 6, 7, 9; LPN #5] the agency failed to obtain a physical examination, including tuberculin test and a physician's statement that the employee is free from communicable diseases, prior to assignment of patient care activities. The findings include:

a. H-HHA #3 with a hire date of 10/7/08 provided patient care on 11/3/08. The personnel file documented that a physical exam with tuberculin testing was not obtained 11/25/08.
b. H-HHA #5 had a hire date of 4/8/08. The personnel file lacked documentation that a physical exam was obtained prior to patient care activities, nor was a physical exam ever obtained.
c. RN #4, without a documented hire date, was assigned to patient care in April 2008. The personnel file lacked documentation of a physical exam and PPD prior to patient care activities.
d. LPN #5 had a hire date of 5/27/08. The personnel file failed to document that a physical exam was obtained prior to patient care activities.
e. RN#1 had a hire date of 10/27/08. The personnel file failed to document that a physical exam with tuberculin testing was obtained prior to patient care activities.
f. RN #3 had a hire date of 5/8/08. The personnel file failed to document that a physical exam with tuberculin testing was obtained prior to patient care activities
g. RN #2 had a hire date of 1/24/08. The personnel file failed to document that a physical exam was obtained prior to patient care activities.
h. Interview on 12/26/08, the agency Administrator/SCS indicated that they were unable to provide documentation that the examinations and/or testing were completed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (a)(2)(C) Patient care policies.

16. Based on clinical record review, agency policy, and staff interviews it was determined that for fourteen (14) of fourteen (14) patients (Patient #s 1-13, 15) with a starts of care prior to the survey dates, the agency failed to forward a written summary to the physician within 10-days of admission and/or at least every 60-days thereafter. The findings include:

a. The clinical records of Patient #s 1, 3, 5, 7 and 15, with start of care dates between 11/03/08-11/27/08, lacked documentation that a summary report had been sent to each of the patients' physicians within 10-days after admission.

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b. The clinical records of Patient #s 2, 4, 6, 8, 9, 10, 11, 12 and 13 with start of care dates between 1/20/08-10/17/08 lacked documentation that a 10-day summary report was forwarded to the physician within 10-days of admission and/or that a summary report was sent to the physician every 60-days thereafter.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72 (a)(3)(A)(iv)(E)(i)(ii) Patient care policies and/or D68(d)(2)(e)(2)(3) General requirements.

17. Based on review of clinical records, agency policy and staff and family interviews, it was determined that for two (2) of fifteen (15) patients (Patient #s 8, 15) the agency failed to follow their policies regarding financial discharge and/or premature discharge and/or to notify the patient/responsible party of any changes orally and in writing of any payment changes. The findings include:

a. Patient #8 had a start of care assessment date of 4/12/08. A skilled nursing infusion visit on 4/26/08 by RN #4 (PCN) was made to administer intravenous immune globulin (IVIG). Physician orders included administer the infusion every 3 weeks. The diagnosis was common variable immune deficiency. During an interview with RN #4 on 12/26/08, he stated that he was a per diem nurse, received only verbal orders from the office, the visits were scheduled every 3 weeks when the infusion was due, and that the office staff sent formal orders to the physician. Visits were made from 4/26/08 through 9/19/08 however, after making arrangements with the primary caregiver (PCG) for an October visit on or around October 3, 2008, RN #4 stated he was instructed by the Administrator/SCS a few days before the visit (couldn't remember exactly when and did not document the communication in the clinical record) to notify PCG that visit would not be made unless the payment issues were resolved. He stated he notified the PCG as instructed by the Administrator/SCS but, when the visit was due, he was notified that payment was not resolved and eventually cancelled the scheduled visit.
Agency policy identified steps to be followed regarding a financial discharge which were not completed by RN #4 including: discharge summary to the physician; and/or contacting the physician about the financial discharge because RN #4 felt that was the responsibility of the office staff; a review of the continuing needs of the patient was not conducted; and/or documentation of conversations held with the Administrator/SCS or the PCG was lacking. Additional policy components not completed included review by the PAC, and/or a post-termination review of the clinical record by the clinical record review committee following the financial discharge.
An interview on 12/26/08 with the Administrator/SCS identified that the case had been accepted from an IV supplier/pharmacy (IV Supplier #1) with the understanding that the IV supplier would pay the agency. When issues of non-payment arose over several months the Administrator stated that they notified the family of discharge. An undated letter signed by the staff-billing agent was in the clinical record addressed to the PCG identifying that the October visit would not be made unless payment was received. During interviews with the Administrator and billing agent on 12/26/08, they stated that the letter had been sent to the PCG and thought it was sent in mid-September, however the billing agent

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later recanted and stated that the letter had only been sent to the insurance company. Interview with the PCG on 1/20/09 identified that the payment source for the visit was never discussed and that RN #4 called twice to postpone infusion for the following day, the first on the day that was originally scheduled and the following day. Each day the patient was kept out of school. On the second day RN #4 announced that he would not be coming because the agency was not being paid for the visit. It took the PCG three (3) additional days to make arrangements for the patient to receive the infusion at Hospital #2, which was out of state, causing the infusion to be approximately a week late.

b. Patient #15 had a start of care date of 11/21/08. Diagnoses included Alzheimer's disease and hypertension. The plan of care dated 11/21/08 to 1/19/09 identified skilled nursing visits 1-2 times a week for 9 weeks to monitor vital signs and safety, assessment of medication management, teach medications, physician notification and emergency action as well as a home health aide 1-3 times a week for 9 weeks to assist with meals, transportation, laundry, housekeeping and shopping. The addendum to the plan of care identified that the aide schedule should be 3-5 times a week for 9 weeks however a written referral from the payor dated 11/20/08 requested HHA 2 hours 5 days per week, homemaker 2 hours 5 days per week, and a companion 5.5 hours 5 days per week to start on 11/21/08 and stop on 12/19/08. Documentation was lacking of communication with the physician regarding the accurate frequency of home health aide visits.

Nursing notes from 12/14/08-12/23/08 documented by RN #1 identified respiratory changes (decreased lung sounds, shortness of breath [SOB], wheezing), however documentation was lacking that the physician was notified of these changes. The nursing note dated 1/3/09 identified that the patient was alert and oriented and vital signs stable; there was no mention of a discharge conference and/or assessment.

During an interview with the Administrator/SCS on 1/9/09, she stated that the agency had received a call from the payor on 1/2/09 notifying the agency that payment for services ended as of 12/19/08 and that she (SCS) notified the PCN (RN #1) on 1/2/09 to make a discharge visit which she believed was made on 1/3/09. The payor's case manager during interview on 1/9/09 stated that on 1/2/09 she was informed by the family that the agency was still providing services so she contacted the agency on 1/2/09 requesting an accounting of all hours of service utilized to determine if it was possible to extend services. She stated that she reminded the agency that the technical stop date was 12/19/08, she did not instruct them to stop providing service. On interview 1/12/09 the receptionist stated that she was under the impression that the patient had been discharged from their service as of 1/3/09 and attempted to contact the aides on the case, was able to contact and cancel the aide who worked from 6:30 AM to 10:00 AM Monday through Friday, but never spoke to, however left a message for H-HHA Aide #8. Interview on 1/12/09 with H-HHA Aide #8, identified that she arrived at the patient's home on 1/5/09 at 10:00 AM, found the patient half off the bed, assisted patient back to bed and called the office telling the receptionist how she found the patient and that the patient was alone in the house. The receptionist told her to leave because the patient was discharged. Interview with RN #1 on 1/21/09 identified that she was not notified that the patient was to be discharged until after her visit on 1/3/09, therefore she did not notify the family and/or assess the safety of the patient and/or develop a plan with the family and/or notify the physician of the discharge and/or complete a discharge summary. The agency policy

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was not followed regarding the premature discharge of a patient requiring ongoing services.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D73(b) Patient care plan.

18. Based on review of clinical records and staff interviews it was determined that for thirteen (13) of fifteen (15) patients (Patient #s 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 15) the agency failed to have all physician plans of care signed by the patient's physicians within twenty-one (21) days. The findings include:

a. Patient #1 had a start of care date of 11/27/08. Diagnoses included malignant pancreatic duct, malignant pleural effusion and dehydration.
The plan of care for the certification period of 11/27/08 through 1/25/09 identified skilled nursing (SN) visits 5-7 times per week to assess/instruct/administer TPN, assess skin, change PICC line dressing weekly, assess anxiety, pain, teach stress control and coping. Documentation was lacking that the orders were signed by the physician as of 1/9/09.

b. Patient #2 had a start of care date of 10/17/08. Diagnoses included sepsis, hypertension, and non-specific skin eruption. The plan of care of 12/16/08 through 2/13/09 included skilled nursing 1-3 times per week to assess skin rash breakdown, assess signs/symptoms (s/s) of hypertension, teach diet, medication compliance and management, teach stress control with coping skills. Physical therapy evaluation was ordered to assess bed mobility, functional transfers, standing tolerance and gait training. The clinical record indicated that the certification and plan of care the period of 10/17/08 through 2/13/09, failed to be signed by the physician as of 1/9/09.

c. Patient #3 had a start of care date 11/03/08. Diagnoses included viral pneumonia and viral disease. The plan of care of 11/03/08 through 1/3/09 included daily skilled nursing visits for administration of medications, arrange outreach support group, teach daily hygiene, infection control, teach use/risk/route/frequency of medication, assess pain, teach stress control and coping skills. Home health aide, MSW and PT services were also ordered.
In addition the clinical record noted that Patient #3 had multiple start of care dates, 11/16/07, 3/7/08 and 11/15/08. Interview on 12/29/08, the Administrator/SCS was unable to explain the multiple starts of care dates.
Review of the clinical record for the start of care date 3/7/08 indicated that the physician orders dated 3/7/08 to 5/5/08 were signed by the physician on 10/27/08; orders for 5/6/08 to 7/4/08 were signed on 10/28/08; orders for 7/5/08 to 9/2/08 were signed on 8/22/08; orders for 9/3/08 to 11/1/08 were signed on 10/27/08 and orders for 11/3/08 to 1/3/09 were not signed as of 1/9/09.

d. Patient #4 had a start of care date of 9/10/08. Diagnoses included bacterial pneumonia, chronic respiratory failure and psychomotor epilepsy. The plan of care for 9/10/08 through 11/10/08 included

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skilled nursing visits 16-24 hours per day to assess skin/respiratory status/vent, tracheotomy care, provide complete bed bath, administer medications, and transfer via Hoyer lift to custom wheelchair. Review of the clinical record indicated that the physician did not sign the plan of care for 9/10/08 until 10/28/08, approximately 48-days later

e. Patient #5 had a start of care date 11/10/08. Diagnosis included open wound knee/leg/ankle. The plan of care for 11/10/08 to 1/08/09 included skilled nursing 5-7 times per week for daily IV medication administration, daily blood sugar checks with insulin administration, wound care to right knee cleanse area with normal saline follow by 4x4 wrap with ace bandage, report changes to physician, teach daily hygiene, cognition assessment, teach medication dispensing device, teach stress control and coping. Home health aide was to visit 5-7 times per week to assist with grooming, ambulation, laundry and housekeeping.
As of 1/9/09, the physician had not signed the plan of care dated 11/10/08.

f. Client #7 had a start of care date of 10/23/08. Diagnoses included diabetes mellitus (DM) type1 and left foot ulcer. The certification period of 10/23/08 to 12/21/08 included skilled nursing visits 1-3 times per week to teach proper administration of IV solutions, assessment of IV site for s/s of complications, assess diabetes, teach diet, infection control, teach wound care. The plan of care dated 10/23/08 was not signed by the physician as of 1/9/09.

g. Patient #8 had a start of care date 3/20/08. At the time of survey no physician orders based on the RN assessment and/or plan of care was available for review, nor was it obtained. Interview 12/29/08, the Administrator /SCS indicated that IV therapy was only being provided; IV Agency #1 had acquired the physician orders.

h. Patient #9 had a start of care date 9/13/08. The diagnosis was bronchopulmonary dysplasia with a tracheotomy. The plan of care for the period of 9/13/08 to 11/11/08 included shift nursing 16-24 hours per day to change G-tube daily, suction patient every hour, assess anxiety, weight gain, diet, activity level, teach medications and wound assessment.
Review of the clinical record indicated that the initial plan of care orders dated 9/13/08 were not signed by the physician as of 1/9/09.

i. Patient #10 had a start of care date 11/6/08. Diagnoses included congestive heart failure and diabetes type 2. The certification period dated 11/6/08 to 1/4/09 included skilled nursing 1-2 times per week to assess cardio-respiratory process, teach diet, medication teaching, and assess signs/symptoms (s/s) of diabetes; physical therapy 1-3 times per week for gait training, bed mobility, functional transfers, and standing tolerance.
The clinical record indicated that the initial plan of care orders dated 11/6/08 were not signed by the physician as of 1/9/09.

j. Patient #11 had a start of care date 8/10/08. The certification period dated 8/10/08-10/10/08 included

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shift nursing 8-20 hours per day 5-7 days per week to assess cardio/pulmonary status, GI/GU status, medication and diet compliance, nutrition/hydration, ADL status; check feeding bag daily, G-tube site care twice per day. The clinical record indicated that the physician did not sign the plan of care dated 8/10/08 until 10/28/08.

k. Patient #12 had a start of care date 3/15/08. The diagnosis was bacteremia. The plan of care for the period of 3/15/08 to 5/13/08 included skilled nursing 1-2 times per week to change PICC line dressing weekly, teach diet activity guidelines, risk/dose/route frequency of medications, teach use of medication dispensing device, assessment of medication management and teach stress and coping skills.
The clinical record indicated that the agency failed to have signed physicians order for the plans of care dated 3/15/08 to 5/13/08, 5/14/08 to 7/12/08, and 7/13/08 to 9/13/08.

l. Patient #13 had a start of care date 9/9/08. Diagnoses included heart failure and atrial fibrillation. The plan of care for the period of 9/9/08 to 11/7/08 included skilled nursing 5-7 times per week to teach diet activity guidelines, risk/dose/route frequency of medications, assessment of medication management and assess weight and edema.
The clinical record indicated that the agency failed to have signed physicians order for the plan of care dated 9/9/08 until 10/21/08 (6 weeks later).

m. Patient #15 had a start of care date of 11/21/08. The diagnosis was Alzheimer's disease. The plan of care dated 11/21/08 to 1/19/09 included skilled nursing visits 1-2 times a week and home health aide visits 1-3 times a week. The physician did not sign the orders until 12/31/08, approximately 6 weeks later.

n. Agency policy identified that the signed orders must be received from the physician within 30-days from the time the agency sends it and must be put in the patients record within 60-days of receipt in the agency's office.

o. Interview with the Administrator/SCS on 12/30/08 identified that the responsibility for getting signed orders/plans of care (PoC) was delegated to the receptionist and that she had not been made aware of any problems however she further stated she was not aware that the orders/PoC were required to be signed within twenty-one days and should be integrated into the patient's record within seven days following receipt

p. Interview with the receptionist on 12/30/08 identified that it was her responsibility to send out the certification/plan of care to the physicians for signature, and then to contact them if they weren't back on a timely basis. However she stated that she did not have a tickler file and/or system to assure they were returned timely and was behind in filing and some orders could be sitting in the stack on her desk.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D73 (b) Patient care plan.

19. Bases on clinical record review it was determined that for two (2) of fifteen (15) patients (Patient #s 4, 8) the agency failed to have the total plan of care reviewed by the physician at least every 60-days. The findings include:

a. Patient #4 had a start of care date of 9/10/08. Diagnoses included bacterial pneumonia, chronic respiratory failure and psychomotor epilepsy. The plan of care for the re-certification period beginning 11/11/08 was not completed and/or available for review at the time of survey.

b. Patient #8 had a start of care assessment date of 4/12/08. A skilled nursing infusion visit by RN #4 (PCN) on 4/26/08 was made to administer intravenous immune globulin (IVIG). Diagnosis was common variable immune deficiency. Physician orders from Hospital #2 were dated 3/20/08 that identified to admit the patient to homecare, vital signs per protocol, insert IV, Tylenol and Benadryl PRN. The clinical record documented nursing visits dated 4/26/08, 5/17/08, 6/12/08, 7/11/08, 8/30/08 and 9/19/08. Ongoing care was provided without signed physician orders for services every 60 days. During an interview with RN #4 on 12/26/08, he stated that he was a per diem nurse, received only verbal orders from the office and that they [the office] sent formal orders to the physician. RN #4 further stated that he was not given any written physician orders for care to be provided and/or did not develop a plan of care.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D73(b) Patient care plan.

20. Based on observations, clinical record review and interviews with agency staff it was determined that for six (6) of fifteen (15) patients (Patient #s 1, 5, 8, 9, 12, 15) the nurse failed to initiate the plan and/or necessary revisions based on the needs of the patient. The findings include:

a. Patient #1 had a documented start of care date of "11/27/08". Diagnosis included malignancy of the pancreatic duct. The certification and plan of care dated "11/30/08 through 1/28/09" identified that the patient required skilled nursing visits 1-3 times a week; orders included to instruct and administer TPN, teach daily hygiene, infection control, and medication management as well as assess pain. The plan of care listed no medication for pain management. A skilled visit note written on 11/27/08 identified that the patient's vital signs were stable, complained of generalized pain, "ordered for pain medication". The start of care OASIS/comprehensive assessment dated 11/30/08 identified that the patient was alert and oriented, consistently anxious, had feelings of depression and hopelessness, was totally dependent for all activities of daily living, had consistent intractable pain.
Interviews with RN #1 on 1/21/09 identified that when she started the case on 11/26/08, she was told to just instruct on the TPN. She never contacted the patient's physician regarding the pain and/or

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alterations to the plan of care.

b. Patient #5 had a start of care date of 12/14/08. Diagnoses included cellulitis and abscess of leg and uncontrolled diabetes mellitus (DM) regarding newly diagnosed Type 1 DM. The start of care OASIS/ comprehensive assessment dated 12/14/08 identified that the patient was alert and oriented, obese, a heavy smoker, lived alone, in constant intractable pain, and required assistance with ADLs and IADLs. The certification and plan of care dated 12/14/08 to 2/11/09 identified that the patient was oriented and depressed, had a fair prognosis and required skilled visits 5-7 x week x 9 weeks to change the porta-cath dressing weekly, daily dressing changes to the right lower leg, assess DM symptoms, blood glucose results, pain, and medication management as well as teach physician notification, infection control and wound care. Home health aide visit needs were 5-7 x a week for ADL assistance.
Joint home visit observations by the surveyor on 12/24/08 identified that the patient was alert, oriented, became easily short of breath (SOB), was receiving O2 via nasal cannula continuously at 2 LPM, used a wheelchair for ambulation however was able to stand and bear weight on the right leg which would not bend at the knee, did not wear slippers and had dry skin on both legs and long thick nails on both feet. The patient stated that he/she had been disabled for two years due to infections following two (2) total knee replacements and a knee fusion, had been turned down for meals on wheels, his/her child did the food shopping, and that the aide that visited helped with a bed bath or shower. The written instructions for the home health aide were not in the home, however the PCN stated that the aides carried them on their persons. The home health aide's written instructions in the computer identified that the aide was to assist with ambulation and grooming, as well as to assist with IADLs and to clip nails as necessary. The nurse failed to initiate an individualized aide care plan to include interventions regarding the dry skin and/or not to clip toe nails. The Administrator/SCS identified that the aides care plans were generated from information fed into the computer system however it was necessary for the nursing staff to add or eliminate pertinent information and care needs.
The care plan failed to include a referral for social services to address the patient's depression, financial concerns, long-term disability and/or podiatry services regarding diabetic needs.
Interviews with the PCN (RN #3) on 12/24/08 and 12/26/08 identified that her primary responsibility was to assure that the IVs infused correctly, to change the central line dressing and the dressing on the right knee wound.

c. Patient #8 had a start of care assessment date of 4/12/08. A skilled nursing infusion visit by RN #4 (PCN) on 4/26/08 was made to administer intravenous immune globulin (IVIG). Diagnosis was common variable immune deficiency. Physician orders from Hospital #2 were dated 3/20/08 that identified to admit the patient to homecare, vital signs per protocol, insert IV, Tylenol and Benadryl PRN. Additional orders dated 4/3/08, from Hospital #2, identified that IVIG/GGSD powder should be increased to 2.5 GM and administered every 3 weeks. A plan of care identifying the visit and treatment plan, based on the admission assessment dated 4/12/08, failed to be developed and/or sent to the physician for signature. The clinical record documented nursing visits dated 4/26/08, 5/17/08, 6/12/08, 7/11/08, 8/30/08 and 9/19/08. Ongoing care was provided without signed physician orders for services on admission.

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During an interview with RN #4 on 12/26/08, he stated that he was a per diem nurse, received only verbal orders from the office and that they [the office] sent formal orders to the physician. RN #4 further stated that he was not given any written physician orders for care to be provided and/or did not develop a plan of care.

d. Patient #9 had a start of care date of 9/13/08. Diagnoses include respiratory abnormality: pulmonary dysphagia, tracheostomy, cleft palate, limb anomalies, aortic stenosis and absence of the left kidney. The plan of care (PoC) of 9/13/08 to 11/11/08, not signed by the physician, included skilled nursing 16-24 hours daily to change G-tube site, suction patient every hour and prn, assess anxiety, phone the physician if the patient had a weight gain of 3 lbs, assess lab values, diet status and activity level, teach daily hygiene, infection control; use, dose, route/frequency of medications; medication management, teach wound care, wound assessment, signs/symptoms of GU process, teach stress control/coping skills and assess equipment management and pain.
The physician's PoC dated 11/12/08 to 1/11/09 included skilled nursing 16-24 hours daily with the same goals, interventions and lack of medications as the previous PoC. The nurse failed to make the necessary revisions to the plan of care to include the nutritional requirements via the G-tube and/or by mouth, G- tube protocol for care and the schedule for change, tracheotomy size/protocol for care and/or emergency equipment that should be in the home.

e. Patient #12 had a start of care date of 3/15/08. The diagnosis was bacteremia. The initial plan of care dated 3/15/08 to 5/13/08 included skilled nursing 1-2x a week to change the peripherally inserted central catheter (PICC) line dressing weekly.
The PoCs dated 3/15/08 through 9/11/08 lacked specific orders of the procedure/protocol for the PICC line dressing change and/or PICC line weekly flush; the agency failed to have a protocol for the weekly PICC line flush.

f. Patient #15 had a start of care date of 11/21/08. Diagnoses included Alzheimer's disease and hypertension. The plan of care dated 11/21/08 to 1/19/09 identified skilled nursing visits 1-2 times a week for 9 weeks and home health aide services 1-3 times a week for 9 weeks to assist with meals, transportation, laundry, housekeeping and shopping. The addendum to the plan of care identified that the aide schedule should be 3-5 times a week for 9 weeks however a written referral from the payor dated 11/20/08 requested HHA 2 hours 5 days per week, homemaker 2 hours 5 days per week, and a companion 5.5 hours 5 days per week to start on 11/21/08 and stop on 12/19/08. Documentation was lacking of communication with the physician regarding the change in the accurate frequency of home health aide visits.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13- D74 (a)(1) Administration of medicines.

21. Based on clinical record review, staff and family interviews it was determined that for one (1) of

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fifteen (15) patients (Patient # 9) the nurse failed to administer drugs and treatments only as ordered by the physician. The findings include:

a. Patient #9 had a start of care date of 9/13/08. Diagnoses include respiratory abnormality: pulmonary dysphasia, tracheostomy, cleft palate, limb anomalies, aortic stenosis and absence of the left kidney. The plan of care (PoC) of 9/13/08 to 11/11/08, not signed by the physician, included skilled nursing 16-24 hours daily to teach use, dose, route/frequency of medications; medication management, and assess equipment management and pain. Although the PoC noted that the nurse would assess medication management the PoC identified the patient was taking no medications.
Nursing notes from 10/5/08 through12/21/08 identified that Patient #9 was having fevers, occasional vomiting and weight loss. The nursing notes identified that the nursing staff was administering medications to treat the fevers as directed by Patient #9's parent; however, the dose/time of the medications were not documented and/or the medications lacked physician orders and were not listed on the PoC or medication list.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D74(b) Administration of medicines.

22. Based on clinical record review and staff interviews for four (4) of fifteen (15) patients (Patient # 5, 9, 12, 14) the nurse failed to include a review of all medications the patient is currently using as a part of the comprehensive assessment. The findings include:

a. Patient #5 had a start of care date of 12/14/08. Diagnoses included cellulitis and abscess of leg and uncontrolled diabetes mellitus (DM) regarding newly diagnosed Type 1 DM. The certification and plan of care dated 12/14/08 to 2/11/09 identified that the patient was oriented and depressed, had a fair prognosis and required skilled visits 5-7 x week x 9 weeks to change the porta-cath dressing weekly, daily dressing changes to the right lower leg, assess DM symptoms, blood glucose results, pain, and medication management as well as teach physician notification, infection control and wound care. Home health aide visit needs were ordered 5-7 x a week for ADL assistance. The list of medications on the certification and plan of care, dated 12/14/08-2/11/09 had several significant misspellings, duplications and/or inappropriate dosage and frequency parameters. For example, insulin was listed three times including (1) insulin 22 s K HS (2) Humalog insulin Lispro Recombinant 5u sc and HS and (3) Lantus - Insulin Glargine Recombinant QHS 40 G 26 units SC once a day. During a joint home visit with RN #3 on 12/24/08, the patient identified that he/she took Humalog insulin 15 units three times a day (TID) and Lantus 55 units at bedtime. RN #3 stated she was unaware of those doses. Other misspelled and/or duplicative orders included Methadone, Vancomycin, Reglan, Lexapro and Morphine.
Interview with the Administrator/SCS and receptionist on 12/26/08 identified that the Addendum to: Plan of Treatment (CMS 487) that included additional medication orders was not being sent with the (CMS 485) to the physician. The oral medications on the complete plan of treatment varied from those

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listed on the W-10 dated 12/12/08 from Hospital #3 and although the patient was on oxygen 2 LPM continuously it was not documented; documentation was lacking of any communication with the physician regarding the medication discrepancies in the plan of treatment and the W-10.

b. Patient #9 had a start of care date of 9/13/08. Diagnoses include respiratory abnormality: pulmonary dysphasia, tracheostomy, cleft palate, limb anomalies, aortic stenosis and absence of the left kidney. The plan of care of 9/13/08 to 11/11/08, not signed by the physician, included skilled nursing 16-24 hours with interventions that included use, dose, route/frequency of medications; medication management and assess pain. The plan of care dated 11/12/08 did not have any medications listed. Although the plans of care noted that the nurse would assess medication management, the plan of care stated that the patient was not taking any medications. The nursing visit notes from 1/5/08 to 12/20/09 indicated that the nurses administered Tylenol, Motrin and Zofran to the patient although the medications were not listed on the plans of care/medication list and the clinical record lacked physicians' orders for the medications.

c. Patient #12 had a start of care date of 3/15/08. The diagnosis was bacteremia. The initial plan of care dated 3/15/08 to 5/13/08 included skilled nursing 1-2x a week with interventions that included to assess/teach use/risk/dose/route/frequency of medications; teach use of medication dispensing device, assessment of medication management. The medications listed on the W-10 included Oxycodone CR 10 mg. po q 12 hours which was not included in the agency's plans of care dated 3/15, 5/14, 7/12 and 9/11/08 and was not clarified with the physician and/or reviewed with the family member/patient.

d. Patient #14 had a start of care date of 1/3/09. Diagnoses included acute renal failure and dehydration Review of the W-10's medication list and the medications listed on the plan of care of 1/3/09 noted that Seroquel was on the plan of care but not on the W-10; Colace, Senna, Metoprolol and Travasol solution were listed on the W-10 but were not included on the physician's plan of care. The clinical record lacked documentation that the nurse clarified the medication discrepancies with the physician.
On the visit of 1/6/09 the nurse called the daughter who said she felt the patient needed daily visits. Upon discussion with the daughter, RN #1 identified that the daughter stated the patient was "misusing medications, that he/she had the daughter leave all the bottles opened at the bedside the previous evening and was acting loopy". EMS was called to the home however the patient refused to go to the hospital. RN #1 and the daughter determined the patient's current medications based on the dates on the bottles and did not verify the current medications using an accurate medication list.
Patient #14 stated during a home visit by the surveyor on 1/6/09 that the pain medication was Dilaudid 2 mg. every 3 hours rather than the 1 mg. identified on the W-10 and the plan of care.
Interview with the administrator/SCS on 1/5/09 identified that she E-faxed the W-10 to RN #1 before the admission visit.
Interview with RN #1 on 1/7/09 identified that she was unaware of an E-fax and at the time of both visits to the patient (1/3/09, 1/6/09), she did not have either the W-10 and/or the plan of care with her, had not conferred with the physician regarding the patient's medication regime and the plan of care was created in the office and not by her.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D76 (a)(c)(1) Quality assurance program.

23. Based on interview with agency staff and review of the Quality Assurance Committee minutes for the years 2007 and 2008 it was determined that the agency failed to complete written reports of the findings of each component or a written summary report of the findings of the quality assurance program. The findings include:

a. In 2007 and 2008, the Quality Assurance Committee failed to document a written report of an annual analysis and summary all findings and recommendations of the Quality Assurance Program.

b. On interview on 2/23/09, the administrator/SCS stated that she was aware that the reports had not been completed as required

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13- D76 (e)(1) Quality assurance program.

24. Based on interview with agency staff and review of the Quality Assurance Committee minutes for the years 2007 and 2008 it was determined that the agency failed to conduct quarterly clinical record reviews. The findings include:

a. In 2007 and 2008 documentation was lacking that the agency completed, at least quarterly, a random sampling of therapeutic cases, representing at least the scope of the agency ' s home care services, to assure that agency policies are followed in providing services.

b. On interview on 2/23/09, the administrator/SCS stated that she was aware that the clinical record reviews had not been completed as required

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D76(f)(1)(2)(3)(4) Quality assurance program.

25. Based on review of the personnel folders and interview with agency staff it was determined that for three (3) of three (3) home health aides and/or five (5) of five (5) professional staff members employed for more than 6 months, the agency/professional supervisor failed to complete a written report on the clinical competence of each direct service staff member following six months of employment and annually thereafter (H-HHA #s 1, 4, 5; RN #s 1, 7, 9; LPN #s 5, 10) The findings include:

a. H-HHA #1 had a hire date of 6/20/07; documentation was lacking of a 6-month and/or an annual evaluation of clinical competence.

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b. H-HHA #4 had a hire date of 6/29/08; documentation was lacking of a 6-month evaluation of clinical competence.
c. H-HHA #5 had a hire date of 4/8/08; documentation was lacking of a 6-month evaluation of clinical competence.
d. RN #4's clinical record failed to have a hire date; no evaluations were documented as completed in the personnel folder. The Administrator/SCS did not remember when RN #4 was hired, or if an evaluation was ever completed.
e. LPN #5 had a hire date of 5/27/08, documentation was lacking of a 6-month evaluation of clinical competence.
f. RN #3 had a hire date of 5/8/08; documentation was lacking of a 6-month evaluation of clinical competence.
g. RN #2 had a hire date of 1/24/08; documentation was lacking of a 6-month evaluation of clinical competence.
h. LPN #10 had a hire date of 5/27/08; documentation was lacking of a 6-month evaluation of clinical competence.
i. Interview on 12/26/08, the Administrator/SCS indicated that evaluations were not completed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D78 Patient's bill of rights and responsibilities.

26. Based on review of the agency's admission packet and staff interview it was determined that the agency failed to have the appropriate "Patient's Bill of Rights and Responsibilities" included in the admission packet. The findings include:

a. The admission packet presented at the time of survey to the surveyors for review identified the "State of Texas Bill of Rights" was included in the packet along with the Texas Home Health Hotline phone number.
b. Interview 12/26/08, the Administrator/SCS indicated that she was unaware that the form that was generated by their computer, was the Texas bill of rights.
c. Patient #14 stated on 1/6/09 that the nurse failed to inform her/him of the agency's name, the nurse's name, how to contact the agency and he/she was not given the Bill of Rights and/or any other admission forms on 1/3/09 the date that he/she was admitted to the agency.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D78(a) Patient's bill of rights and responsibilities.

27. Based on clinical record review and staff interviews it was determined that for fifteen (15) of fifteen (15) patients (Patient #s 1-15), the agency failed to inform the patient orally and in writing of the payer source to be utilized for the services to be rendered by the agency. The findings include:

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a. The clinical records for Patient #s 1-15, indicated that the agency failed to include the payer source on the patients' consent and verification of receipt information form which the patient was to sign on admission. The clinical record lacked any other documentation that identified the appropriate source of reimbursement for services rendered.
b. Agency policy identified that during the admission visit, The RN must inform the patient verbally and in writing of the payor source for services provided and/or any charges the patient might be responsible for assuming.
c. The administrator/SCS stated on 1/27/09 that the expectation would be for the nurse to include/write the payor source on the agency ' s patient consent and verification form during admission to the agency.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D78(h) Patient's bill of rights and responsibilities

28. Based on observation and staff interviews it was determined that the confidentiality of patient information was not being maintained at all times for agency patients. The findings include:

a. Observations of the receptionist area of the agency identified that the receptionist had access and at times reviewed clinical information on her computer. The computer in the work area was situated so as to be easily visible to anyone being assisted by and/or waiting for the receptionist. On several occasions during the period of 12/23/08 through 12/26/08 it was observed that the receptionist left the work area with patient information visible on the computer and a stack of papers, as well as a notebook, on the desk-top that included active patient's certifications and plans of care and other clinical information, including OASIS data, related to the patients. During an interview with the receptionist on 12/26/08 she identified that she was responsible to send out and file completed plans of care and that the stack on her desk was waiting for signatures and/or to be filed. She further stated that she was able to access patient records on her computer through their record system.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D78(k)(l) Patient's bill of rights and responsibilities.

29. Based on review of the clinical records, the agency complaint log and staff interviews it was determined that the agency failed to maintain a complaint log which included the date, nature of the complaint and the resolution to the complaint and/or failed to investigate complaints made by a patient, their family and/or guardian. The findings include:

a. The agency failed to provide a complaint log for review by the surveyors.

b. Interview December 26, 2008 with the agency Administrator/SCS indicated that a complaint log was

not maintained by the agency; only an answering service log was completed.

c. Patient #8 had a start of care assessment date of 4/12/08 and a skilled nursing infusion visit on 4/26/08 was made to administer intravenous immune globulin (IVIG) by RN #4, (PCN). Physician orders included skilled nursing to administer infusion every 3 weeks. Visits were made approximately every 3 weeks through September 2008. Although a visit was scheduled for October 2008, RN #4 made several calls to reschedule and then cancelled the visit due to non-payment issues. During an interview with the primary care giver (PCG) on 1/20/09, it was identified that despite the fact the PCG had contacted the agency to complain, there was no resolution and he/she was forced to make alternative arrangements for the patient's ongoing infusion. Review of the complaint log on 12/23/08 identified the complaint had not been entered. During an interview with the Administrator/SCS on 12/26/08, she identified that although the PCG complained to them they were forced to discharge because the agency had not been paid for any of their visits however the Administrator/SCS was not able to identify the reason the complaint had not been logged.